



5530 W. Emerald
Boise, ID 83706
www.southworthassociates.net



**Interventions
Consulting
Monitoring**

Corporate Office: 208.323.9555
Toll Free: 800.386.1695
Fax: 208.323.9222

DEMOGRAPHICS

Legal Name (First, Middle, Last):		
SSN:	Date of birth:	SEX: Male___ Female___
Address:	Phone Numbers:	
EMPLOYMENT: Patient's Occupation:		
ALCOHOL/DRUG USE:		
1st Preferred Substance:	2nd Preferred Substance:	
3rd Preferred Substance:	4th Preferred Substance:	
Date of Last drink/use:		
How long has patient been drinking/using this way?		
How much typically drank/used:		
What is patient's longest period of sobriety?		
MENTAL HEALTH HISTORY: Psychological Diagnosis?		
Active Bulimia/Anorexia?		
Is patient presently feeling suicidal?	Homicidal?	Self-injury history?
Any recent suicide attempts?		
If so, please give details and date of attempt:		
Is the patient ambulatory? If not, please explain:		
ALCOHOL/DRUG TREATMENT: Has patient had any previous treatment?		
If so, when and where and how many days?		
MEDICAL TREATMENT: Any medical problems? If so, please explain:		
Has patient recently been hospitalized?	If so, when and for what?	
MEDICATIONS: Current medications:		
Reason for use:	Frequency and doses:	
REFERRAL INFORMATION: Name, Address & Phone Number of Referent:		
EMERGENCY CONTACT: Name, Address & Phone Number of Emergency Contact:		

Southworth Associates Pre-Admission Assessment

CONSEQUENCES OF ALCOHOL/DRUG USE OR MENTAL HEALTH ISSUES
(please list all applicable consequences)

Legal Consequences:

Occupational Consequences:

Financial Consequences:

Health Consequences:

Social & Family Consequences:

PAYMENT INFORMATION

PAYMENT: Expected Method of Payment for **Treatment:**

Cash () Cashier's Check () Money Order ()

Credit Card - see attached form () Insurance – see below ()

Name of Insured (if different from patient):

Name of Carrier:

Phone number of carrier:

Group Number:

Member or ID Number:

Social Security Number of Insured:

Name of Insured's Employer:

PAYMENT: Expected Method of Payment for **Intervention:**

Personal Check – see below () Cashier's Check – see below ()

Money Order – see below () Credit Card –see attached form ()

Personal Check – Must be received & deposited one week prior to intervention

Cashier's Check/Money Order – Must be received & deposited one week prior to intervention

PATIENT TRAVEL INFORMATION

(If patient will be picked up by Treatment Center staff)

Transportation mode:

Originating city:

Arrival date and time:

If arriving by plane: Airline name and flight number:

Description of patient:

Height:

Weight:

Hair Color:

Outstanding features (glasses, etc.):

Additional Notes:



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Consent for Payment: Intervention & Escort

This form must be signed and faxed to Southworth Associates, LLC at (208) 323-9222

Interventionist: _____ **Date of Intervention:** _____

Payment Amount: _____

I agree to pay the above amount to Southworth Associates, LLC and understand that this amount is non-refundable.*

Authorized Signature: _____ **Date:** _____

Method of Payment: **Wire Transfer**

(Please mark one)

Credit Card: **Visa** **MasterCard** **Discover** **American Express**

Wire Transfer Information:

Bank Name: Regal Financial Bank
Account Name: Southworth Associates, LLC

Routing Number: 125008644
Account Number: 0180005100

Credit Card Information:

Name as it appears on Credit Card: _____

Billing Street Address: _____ **Zip/Postal Code:** _____

Card Number: _____ **Expiration Date:** ____/____

Card ID Number: _____ (Visa & MasterCard – last three digits on back of card; Discover – on back of card; American Express – on front of card above the card number)

*In the case of an intervention where the client doesn't go to treatment, any recoverable expenses will be refunded, but professional fees remain non-refundable. When submitted as a quote for an upcoming intervention, the price listed is only good for 24 hours due to the increasing costs associated with intervention expenses. Once payment is received the interventionist's time is reserved and travel reservations are made. Excess notation on this authorization renders it void.

For Office Use Only

Authorization Code: _____ Date: _____ Initials: _____

WAIVER OF CLAIMS and HOLD HARMLESS

The undersigned, _____
 (“Responsible Party,” who may be the same as “Services Recipient”), in consideration for services given by Southworth Associates, LLC, its officers, agents and/or employees (“Southworth”) for on or behalf of _____ (“Services Recipient”) hereby waives and releases, acquits, satisfies, discharges, indemnifies, defends and holds harmless Southworth from all and all manner of action and actions, causes, damages, judgments or demands of any nature, which may be asserted against Southworth by reason of any matter arising from any services, or acts or omissions of any nature whatsoever, without limitation, provided by Southworth up to and after the date of this Waiver of Claims and Hold Harmless on behalf of Services Recipient or any other person in connection therewith. This Waiver of Claims and Hold Harmless shall be binding on the person signing, his or her heirs, executors, administrators and assigns and successors.

Responsible Party

Date